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Michael F. Easley, Governor

Dempsey Benton, Secretary

April 17, 2008

MEMORANDUM

TO: Joint Legislative Oversight Committee on Mental Health Developmental Disabilities and Substance Abuse Services

FROM: Dempsey Benton

SUBJECT: 2008-2009 Program for MH/DD/SAS

Previous memos have focused on the programs which are considered necessary to be addressed at this time. This memo provides a more specific delineation of action which is proposed to be implemented through legislation, budgetary approval, and department execution in 2008-2009.

I. State Psychiatric Hospitals

A. Budget funding for State's share of a 60 bed adult admission unit at Dorothea Dix, following merger of Dix and Umstead hospitals into Central Regional Hospital. The goal would be to be operational in July, 2008.

B. Funding for additional staff at the State psychiatric hospitals. In January, 2008, I appointed a workgroup to review the management and operations of the State hospitals. In late March, 2008, the groups provided an interim report to me. Their most significant recommendation involves the need to improve staff to patient ratios. The group's staff proposal involves significant funding and may necessitate a multiyear strategy.

It is proposed that the department retain a consultant to follow up on the staff to patient ratio issue and provide a report to the department and committee. This would be used to establish a policy for addressing the staffing levels at the State psychiatric hospitals and ADATCs.

C. Funding for strengthening the department level oversight of State hospitals to facilitate internal inspections and corrections to assure compliance with regulatory agencies.

D. Funding for recruitment incentives for hard to fill positions in the State operated facilities.

II. Crisis Services

A. It is proposed that the statewide crisis services system be enhanced by the following improvements:

a) Establishment of a statewide network of mobile crisis teams (total of 30).
b) Establishment of a statewide network of DD START Crisis Teams (total of 9).
c) Procurement of 187 community inpatient beds to assure availability on a 24/7 basis, and 24 DD crisis respite beds.
d) Establishment of walk-in crisis and immediate after care capacity across the State by funding of new psychiatric, nurse, and social worker positions. These positions would support mobile crisis teams, oversee efforts by LMEs to transition consumers from hospitals back to communities.

This plan has been developed by a Crisis Service Workgroup created in January, 2008. See *Attachment 1.*

B. The execution of these proposals, if approved, would be under direct supervision by the department with contracting with LMEs where applicable.

III. Provider System

A. It is proposed that legislation be passed to modify the recipient and provider appeal system. A proposal was submitted to the committee on March 26, 2008.

B. It is proposed that the provider qualifications be addressed by legislation requiring national accreditation for all current providers within 3 years from the date they started delivering service, that the legislation include accreditation progress requirements, and that all future providers be required to achieve national accreditation within 2 years. See *Attachment 2.*

IV. System Management

A. The Mercer report provides, for the first time, a statewide review of LMEs. While there is debate about the comparative analysis, it is essential to acknowledge the analytical perspective from a highly qualified team with a national experience. This report addresses actual conditions at a given time. It did not take into account long range plans or visions of changes that are being considered. It also speaks to activities which continue and that are at variance with the divestiture directives in the Mental Health Reform effort.

At this time, the State – LME arrangement does not meet the general definition of a "system". It is more realistically described as 25 separate systems of management. In the aggregate, the State pays $132,135,771 to the LMEs for administration. The total management staff in the 25 LMEs is 1,666 plus another 560 staff involved in service delivery. The Utilization review function is separate between the LMEs and the State. Management of key services varies by LME. The continuation of care for consumers discharged from State hospitals is an example. Under the operating agreement between the State and LMEs, there are specific tasks for LMEs to address. The degree to which they are executed day by day varies among LMEs.

Attachment 3 is a proposal to pursue a regional consolidation to achieve a target of up to 9 regional entities over a 3 year period.
It would be offered as a voluntary approach.
It would be incremented and <u>not</u> a statewide effort at one time.
It would provide a basis for delegation of all utilization review functions to a regional group.
It would encourage cost savings and sharing so that the administrative savings can be reinvested into services to consumers.
It provides the basis for LMEs to collaborate on a plan that would utilize their respective strengths.

B. It is proposed that the General Statutes be changed to:
Allow the Governor to appoint one third of the area authority board of directors;
Allow the Secretary of DHHS to concur in the appointment of Area Director;
Modify the time process to allow the Secretary to remove functions from an LME upon determination of insufficiency. See *Attachment 1*.

These adjustments will assist the State-LME network in operating more as a "system" of management for MH/DD/SAS.

Attachment 4 is a planning document which reflects how these proposals could be addressed over a 3 year period if adopted. .

Draft Report

Report to the Secretary - Department of Health and Human Services

Crisis Services Recommendations for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Submitted by: Foster Norman, Amy Blackwell, Wendy Webster, Sarah Wiltgen, Dr. David Rubinow, Jack Naftel, Dr. Tony Lindsay, Ellen Holliman, Mike Watson, Barbara Beatty, Patrice Roesler, John Tote, Robin Huffman, Dr. Marvin Swartz, Dr. Brent Myers, Dr. Darlene Menscer, Carl Britton-Watkins, Peter Mumma, Mike Hennike, Mike Lancaster, Leza Wainwright, Mike Vicario, Yvonne Copeland, Tara Larson, Linda Povlich, Stuart Berde, Walker Wilson, Jack St. Clair

March 27, 2008

Secretary Dempsey Benton established this work group in order to assist the Department of Health and Human Services and Division of Mental Health Developmental Disabilities and Substance Abuse Services in their efforts to provide necessary and appropriate crisis services to citizens of this state. More specifically the Secretary charged the work group as follows:

1. Review the state's current implementation of the crisis services plan.

2. Identify gaps and deficiencies in essential core crisis services.

3. Refine and define the core essential elements in the crisis system.

4. Evaluate the state's current provision of inpatient psychiatric services at the community level which includes inpatient bed capacity. Inpatient bed capacity that is actively in use and unused should also be reviewed.

5. Assess current inpatient psychiatric bed contractual arrangements vis a vis LMEs and in relation to the state's psychiatric hospitals.

6. Examine incentivization strategies for added bed capacity if additional capacity is required.

7. Make specific recommendations including resource requirements for establishing/expanding core essential crisis services for the state.

In January 2008, the crisis services work group began meeting twice a month in two hour work sessions (not including assignments from the group for independent study) pursuant to the Secretary's charge.

The crisis services work group reviewed the crisis system based upon three fundamental elements. Those core functional elements were as follows:

1. **Access** There must be a clearly understood, well defined, consistent and easy to use mechanism for a person in crisis to access crisis services in all communities across the state.

2. **Assessment** There must be a consistent (available any time) provision for persons in crisis to obtain a clinical assessment which is conducted face to face by a licensed qualified clinician. This assessment should be available in a timely manner as defined by being within 30 minutes or 30 miles of every citizen of North Carolina.

3. **Intervention/Disposition** The system should provide an array of crisis intervention services that are commensurate with the needs and acuity of the person experiencing a crisis. The array of crisis services should entail a continuum from lesser to greater intervention intensities.

The crisis work group produced the following findings consistent with the charge by the Secretary:

1. Upon review of the current crisis implementation plan there are significant gaps in crisis services which vary from one area to another across the state. The variance includes quantity of crisis services as well as types of services available.

2. The gaps in core crisis services include insufficient assessment capability in order to determine the person's requirement for intervention by type and intensity. Assessment is also not consistently available within recommended parameters (i.e. 30 minutes/30 miles).

3. Access to screening triage and referral (STR) for persons potentially in need of emergent services are substantially compliant with acceptable standards. In those few exceptions immediate compliance should be expected and required.

4. A finding in relation to crisis disposition/intervention is that there are significant inpatient psychiatric bed capacity short falls for short-term acute inpatient admissions which results in an extraordinarily high volume of admissions to the state's psychiatric hospitals. Inadequate community hospital inpatient bed availability has widespread negative system impacts that are evident in terms of costs to a variety of community service agencies including community EDs, law enforcement, and to the consumers and their families.

   The inadequacy of crisis service intervention also includes mobile crisis team coverage across the state which can obviate the need for some inpatient bed day demands and can produce positive cost benefit outcomes including a better match with acuity and service intensity.

5. A finding of the work group is that inpatient community psychiatric bed capacity is not operating at levels consistent with need or potential capacity as a function of resource issues particularly for indigent care. There are also issues of service provision arrangements that require better partnering among those agencies with vested interests (local MH/DD/SAS/Community hospitals/state psychiatric hospitals).

6. A finding of consequence for crisis services is that the relative unavailability of psychiatry services hampers both crisis prevention and crisis follow-up. Hence crisis service demand reduction options are extremely limited. Psychiatry resources are also an essential component in the assessment service arena as well as intervention/disposition.

7. A finding by the crisis work group is that disability specific crisis service deficiencies are endemic across the state. The poor availability and lack of expertise of crisis services for persons with developmental disorders is wide-spread and significant. This results in either no services or inappropriate admissions to the state's psychiatric hospitals.

Recommendations The crisis services work group respectfully submits the following recommendations to the Secretary of the Department of Health and Human Service:

1. Consumer access through STR across the system is essentially compliant with Division of MH/DD/SAS requirements. There were a few LMEs with deficiencies which must be rectified.

2. Assessment is a core service element and needs to be available 24/7 on a 30/30 (minutes/mile) basis across North Carolina. In order to affect this requirement the system should have at minimum 30 mobile crisis teams strategically located based on relevant dimensions such as population density and geography. A regional view of this distribution of mobile crisis teams is recommended. A tentative budget estimate for this service expansion is $5.7 million recurring and $1.1 million non-recurring.

3. Consistent with the findings of inadequate crisis services statewide for persons with developmental disabilities, it is recommended that 9 teams of professionals with DD expertise be developed and distributed across the three state regions permitting three teams in each region. These teams of DD experts should be managerially tied to the state developmental centers for recruitment, training and technical reasons. The teams should be stationed for strategic coverage in the regions comparable to the rationale for mobile crisis teams.

4. The DD crisis team leaders should have authorization authority for any use of state psychiatric hospital beds for DD persons experiencing a crisis as well as authorization authority for the crisis respite beds that are recommended for the

DD crisis system. The cost for the establishment of 9 DD crisis teams statewide is approximately $4,241,570 recurring and $204,459 nonrecurring.

5. It is recommended that additional inpatient psychiatric bed capacity be created for short term acute admissions (7-10 days) at the community level across the state.

6. It is recommended that 187 beds (for involuntary commitment) not now in use/existence be brought on-line in order to significantly reduce the volume of admissions to the state psychiatric hospitals for acute short term lengths of stay. This will also provide inpatient services closer to communities and families.

7. The work group recommends that all system components partner to effect the added capacity (local MH/DD/SAS, community hospitals and state hospitals).

8. The additional inpatient bed capacity at the community level should also be strategically developed across the state to facilitate consumer access with a goal of 60 miles/90 minutes at a maximum. The approximate cost of 187 additional inpatient beds is $20,066,920 recurring and $2,500,000 nonrecurring.

9. The work group also recommends an appropriation for payment of 20% of indigent care for IVC inpatient beds as a means of reinforcing and retaining current capacity. The cost is estimated to be approximately $7,547,470 new funds.

10. The work group, in keeping with its finding of woefully inadequate crisis intervention/disposition services for persons with DD in crisis, recommends the establishment of 6 crisis respite facilities (total of 24 beds) strategically located with two facilities in each region. These crisis beds should be clinically linked to the DD crisis teams in each region for maximum utilization and should be authorized by the DD crisis teams for utilization.

11. A finding of inadequate psychiatry capacity requires a "walk in" clinical capability across the state for crisis follow up and crisis prevention. The added psychiatry capacity (30 psychiatrists) should also be utilized for post crisis support of persons discharged from inpatient facilities including the state hospitals. Coordination with mobile crisis teams would enhance crisis service delivery.

12. The work group also recommends the use of telepsychiatry as an efficient and effective means of extending psychiatry capacity. The resource requirement for walk-in in crisis and after care capacity is approximately $4,462,065 recurring* and $1,650,000 nonrecurring.

*includes nurse and social work walk-in clinical support

Summary

This report has focused on those areas of crisis services that are the most critical in reducing service gaps. The report also attempts to identify resources necessary to eliminate those gaps.

The work group will prioritize broader significant system concerns that directly or indirectly impact crisis services but are more general than the critical gaps that have been identified. These more general issues will be presented in a subsequent report.

Proposed Statutory Changes

§ 122C-81. National Accreditation Benchmarks.

(a) Definition. – As used in this section, the term "nation accreditation" applies to accreditation by an entity approved by the Secretary that accredits mental health, developmental disabilities, and substance abuse services.

(b) The Secretary, through the Medicaid State Plan, Medicaid waiver, or rules adopted by the Secretary, shall designate the mental health, developmental disabilities and substance abuse services which require national accreditation.

(c) **(For facilities enrolled with the Medicaid program prior to July 1, 2008)** Facilities providing services which require national accreditation per the approved Medicaid State Plan shall successfully complete national accreditation requirements within three years of enrollment with the Medicaid program. Facilities will meet the following benchmarks to ensure continuity of care for consumers in the event the provider does not make sufficient progress in achieving national accreditation in a timely manner:

(1) Nine months prior to the accreditation deadline - Formal selection of an accrediting agency as documented by a letter from the agency to the facility acknowledging the facility's selection of that accrediting agency. A facility failing to meet this requirement will be prohibited from admitting new clients to service. The LMEs will work with a facility failing to meet this deadline to transition clients currently receiving service to other facilities at the rate of ten percent (10%) of the facility's caseload each month. The facility will have its enrollment in the Medicaid program terminated within nine months of failure to meet this deadline.

(2) Six months prior to the accreditation deadline – An on-site accreditation review scheduled by the accrediting agency as documented by a letter from the agency to the facility. A facility failing to meet this requirement will be prohibited from admitting new clients to service. The LMEs will work with a facility failing to meet this deadline to transition clients currently receiving service to other facilities at the rate of twenty percent (20%) of the facility's caseload each month. The facility will have its enrollment in the Medicaid program terminated within six months of failure to meet this deadline.

(3) Three months prior to the accreditation deadline - Completion of an on-site accreditation review, receipt of initial feedback from accrediting agency, and submission of a Plan of Correction for any deficiencies noted by the accrediting agency. A facility failing to meet this requirement will be prohibited from admitting new clients to service. The LMEs will work with a facility failing to meet this deadline to transition clients currently receiving service to other facilities at the rate of thirty-three percent (33%) of the facility's caseload each month. The facility will have its enrollment in the Medicaid program terminated within three months of failure to meet this deadline.

(4) Accreditation deadline – Approval as fully accredited by the national accrediting agency. A facility failing to meet this requirement will be prohibited from admitting new clients to service. The LMEs will work with a facility failing to meet this deadline to transition clients currently receiving service to other facilities within sixty days. The facility will have its enrollment in the Medicaid program terminated within sixty days of failure to meet this deadline.

(d) **(Effective for facilities enrolled in the Medicaid program or contracting for state funded services on or after July 1, 2008)** Facilities providing services which require national accreditation shall successfully complete all accreditation requirements and be awarded national accreditation within two years of enrollment in the Medicaid program or within two years following the facility's first contract to deliver a state-funded service requiring national accreditation. Facilities providing services which require national accreditation will be required to discontinue service delivery and will have their Medicaid enrollment and any service contracts terminated if they do not meet the following benchmarks for demonstrating sufficient progress in achieving national accreditation following the date of enrollment in the Medicaid program or initial contract for state-funded services:

(1) Six months - Formal selection of an accrediting agency as documented by a letter from the agency to the facility acknowledging the facility's selection of that accrediting agency.

(2) Nine months – Completion of self-study and self-evaluation protocols distributed by the selected accrediting agency.

(3) One year – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the facility.

(4) Eighteen months – Completion of on-site accreditation review and receipt of initial feedback from accrediting agency.

(5) Twenty-one months – Acknowledgement from accrediting agency that any deficiencies noted in initial review have been satisfactorily addressed.

(6) If a facility's Medicaid enrollment or service delivery contracts are terminated as a result failure to meet accreditation benchmarks or failure to continue to be nationally accredited, the facility will work with the LME to transition consumers served by the facility to other service providers in an orderly fashion within sixty days of notification by the LME of such failure.

§ 122C-112.1. Powers and duties of the Secretary.

(a) The Secretary shall do all of the following:

(1) Oversee development and implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Enforce the provisions of this Chapter and the rules of the Commission and the Secretary.

(3) Establish a process and criteria for the submission, review, and approval or disapproval of LME business plans submitted by area authorities and county programs for the management of mental health, developmental disabilities, and substance abuse services.

(4) Adopt rules specifying the content and format of LME business plans.

(5) Review LME business plans and, upon approval of the plan, certify the submitting area authority or county program to manage the delivery of mental health, developmental disabilities, and substance abuse services in the applicable catchment area.

(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, county programs, and all providers of public services with State and federal policy, law, and standards. The procedures shall include the development and use of critical performance measures and report cards for each area authority and county program.

(7) Conduct regularly scheduled monitoring and oversight of area authority, county programs, and all providers of public services. Monitoring and oversight shall be used to assess compliance with the LME business plan and implementation of core LME functions. Monitoring shall also include the examination of LME and provider performance on outcome measures including adherence to best practices, the assessment of consumer satisfaction, and the review of client rights complaints.

(8) Make findings and recommendations based on information and data collected pursuant to subdivision (7) of this subsection and submit these findings and recommendations to the applicable area authority board, county program director, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.

(9) Provide ongoing and focused technical assistance to area authorities and county programs in the implementation of the LME functions and the establishment and operation of community-based programs. The technical assistance required under this subdivision includes, but is not limited to, the technical assistance required under G.S. 122C-115.4(d)(2). The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities and county programs in achieving these functions.

(10) Operate State facilities and adopt rules pertaining to their operation.

(11) Develop a unified system of services provided at the community level, by State facilities, and by providers enrolled or under a contract with the State and an area authority or county program.

(12) Adopt rules governing the expenditure of all funds for mental health, developmental disabilities, and substance abuse programs and services.

(13) Adopt rules to implement the appeal procedure authorized by G.S. 122C-151.2.

(14) Implement the uniform portal process developed under rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services in accordance with G.S. 122C-114.

(15) Except as provided in G.S. 122C-26(4), adopt rules establishing procedures for waiver of rules adopted by the Secretary under this Chapter.

(16) Notify the clerks of superior court of changes in the designation of State facility regions and of facilities designated under G.S. 122C-252.

(17) Promote public awareness and understanding of mental health, mental illness, developmental disabilities, and substance abuse.

(18) Administer and enforce rules that are conditions of participation for federal or State financial aid.

(19) Carry out G.S. 122C-361.

(20) Monitor the fiscal and administrative practices of area authorities and county programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area authorities and county programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles.

(21) Provide technical assistance, including conflict resolution, to counties in the development and implementation of area authority and county program business plans and other matters, as requested by the county.

(22) Develop a methodology to be used for calculating county resources to reflect cash and in-kind contributions of the county.

(23) Adopt rules establishing program evaluation and management of mental health, developmental disabilities, and substance abuse services.

(24) Adopt rules regarding the requirements of the federal government for grants-in-aid for mental health, developmental disabilities, or substance abuse programs which may be made available to area authorities or county programs or the State. This section shall be liberally construed in order that the State and its citizens may benefit from the grants-in-aid.

(25) Adopt rules for determining minimally adequate services for purposes of G.S. 122C-124.1 and G.S. 122C-125.

(26) Establish a process for approving area authorities and county programs to provide services directly in accordance with G.S. 122C-141.

(27) Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance abuse.

(28) Enforce the protection of the rights of clients served by State facilities, area authorities, county programs, and providers of public services.

(29) Adopt rules for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, county programs, and providers of public services.

(30) Prior to requesting approval to close a State facility under G.S. 122C-181(b):

a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure; and

b. Present a plan for the closure to the members of the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.

(31) Ensure that the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan and NC Health Choice.

(32) Implement standard forms, quality measures, contracts, processes, and procedures to be used by all area authorities and county programs with other public and private service providers. The Secretary shall consult with LMEs, CFACs, counties, and qualified providers regarding the development of any forms, processes, and procedures required under this subdivision. Any document, process, or procedure developed under this subdivision shall place an obligation upon providers to transmit to LMEs timely client information and outcome data. The Secretary shall also adopt rules regarding what constitutes a clean claim for purposes of billing.

When implementing this subdivision, the Secretary shall balance the need for LMEs to exercise discretion in the discharge of their LME functions with the need of qualified providers for a uniform system of doing business with public entities.

(33) Develop and implement critical performance indicators to be used to hold LMEs accountable for managing the mental health, developmental disabilities, and substance abuse services system. The performance system indicators shall be implemented no later than July 1, 2007.

(34) Adopt rules for the implementation of a co-payment graduated schedule to be used by LMEs and by contractual provider agencies under G.S. 122C-146. The co-payment graduated schedule shall be developed to require a co-payment for services identified by the Secretary. Families whose family income is three hundred percent (300%) or greater of the federal poverty level are eligible for services with the applicable co-payment.

(35) Approve the selection of the Area Director.

(36) Adopt rules for the endorsement and monitoring of providers of mental health, developmental disabilities and substance abuse services.

(b) The Secretary may do the following:

(1) Acquire, by purchase or otherwise in the name of the Department, equipment, supplies, and other personal property necessary to carry out the mental health, developmental disabilities, and substance abuse programs.

(2) Promote and conduct research in the fields of mental health, developmental disabilities, and substance abuse; promote best practices.

(3) Receive donations of money, securities, equipment, supplies, or any other personal property of any kind or description that shall be used by the Secretary for the purpose of carrying out mental health, developmental disabilities, and substance abuse programs. Any donations shall be reported to the Office of State Budget and Management as determined by that office.

(4) Accept, allocate, and spend any federal funds for mental health, developmental disabilities, and substance abuse activities that may be made available to the State by the federal government. This Chapter shall be liberally construed in order that the State and its citizens may benefit fully from these funds. Any federal funds received shall be deposited with the Department of State Treasurer and shall be appropriated by the General Assembly for the mental health, developmental disabilities, or substance abuse purposes specified.

(5) Enter into agreements authorized by G.S. 122C-346.

(6) Notwithstanding G.S. 126-18, authorize funds for contracting with a person, firm, or corporation for aid or assistance in locating, recruiting, or arranging employment of health care professionals in any facility listed in G.S. 122C-181.

(7) Contract with one or more private providers or other public service agencies to serve clients of an area authority or county program and reallocate program funds to pay for services under the contract if the Secretary finds all of the following:

a. The area authority or county program refuses or has failed to provide the services to clients within its catchment area, or provide specialty services in another catchment area, in a manner that is at least adequate.

b. Clients within the area authority or county program catchment area will either not be served or will suffer an unreasonable hardship if required to obtain the services from another area authority or county program.

c. There is at least one private provider or public service agency within the area authority or county program catchment area, or within reasonable proximity to the catchment area, willing and able to provide services under contract.

Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and to the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(8) Contract with one or more private providers or other public service agencies to serve clients from more than one area authority or county program and reallocate the funds of the applicable programs to pay for services under the contract if the Secretary finds either that there is no other area authority or county program available to act as the administrative entity under contract with the provider or that the area authority or county program refuses or has failed to properly manage and administer the contract with the contract provider, and clients will either not be served or will suffer unreasonable hardship if services are not provided under the contract. Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(9) Require reports of client characteristics, staffing patterns, agency policies or activities, services, or specific financial data of the area authority, county program, and providers of public services. The reports shall not identify individual clients of the area authority or county program unless specifically required by State law or by federal law or regulation or unless valid consent for the release has been given by the client or legally responsible person. (2001-437, s. 1.7(b); 2006-142, s. 4(m); 2007-410, s. 2; 2007-504, s. 2.2.)

§ 122C-114. Powers and duties of the Commission.

(a) The Commission shall have authority as provided by this Chapter, Chapters 90 and 148 of the General Statutes, and by G.S. 143B-147.

(b) The Commission shall adopt rules regarding all of the following:

(1) The development of a process for screening, triage, and referral, including a uniform portal process, for implementation by the Secretary as required under G.S. 122C-112.1(14).

~~(2) LME monitoring and endorsement of providers of mental health, developmental disabilities, and substance abuse services.~~

(3) LME provision of technical assistance to providers of mental health, developmental disabilities, and substance abuse services.

(4) The requirements of a qualified public or private provider as that term is used in G.S. 122C-141. In adopting rules under this subsection, the Commission shall take into account the need to ensure fair competition among providers. (C.S., s. 6153; 1929, c. 265, s. 1; 1933, c. 342, s. 1; 1943, cc. 32, 164; 1945, c. 952, s. 9; 1947, c. 537, s. 5; 1957, c. 1232, s. 1; 1959, c. 348, s. 3; c. 1002, s. 3; c. 1028, ss. 1, 2, 3, 5; 1963, c. 451, s. 1; c.

1166, s. 10; 1973, c. 476, s. 133; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 2007-504, s. 2.3.)

§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet all the following minimum qualifications:

a. Masters degree.

b. Related experience.

c. Management experience.

d. Any other qualifications required under G.S. 122C-120.1.

(3) Repealed by Session Laws 2006-66, s. 10.32(e), effective July 1, 2007.

(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.

(5) Written notification to the Secretary prior to the termination of the interlocal agreement.

(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements provided in G.S. 122C-118.1.

(b) Before establishing a county program pursuant to this section, a county board of commissioners shall hold a public hearing with notice published at least 10 days before the hearing.

(c) A county shall ensure that the county program and the services provided through the county program comply with the provisions of this Chapter and the rules adopted by the Commission and the Secretary.

(d) A county program shall submit on a quarterly basis to the Secretary and the board of county commissioners service delivery reports that assess the quality and availability of public services within the county program's catchment area. The service delivery reports shall include the types of services delivered, number of recipients served, and services requested but not delivered due to staffing, financial, or other constraints. In addition, at least annually, a progress report shall be submitted to the Secretary and the board of county commissioners. The progress report shall include an assessment of the progress in implementing local service plans, goals, and outcomes. All reports shall be in a format and shall contain any additional information required by the Secretary or board of county commissioners.

(e) Within 30 days of the end of each quarter of the fiscal year, the program director and finance officer of the county program shall present to each member of the board of county commissioners a budgetary statement and balance sheet that details the assets, liabilities, and fund balance of the county program. This information shall be read into the minutes of the meeting at which it is presented. The program director or finance officer of the county program shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.

(f) In a single-county program, the program director shall be appointed by the county manager, subject to approval by the Secretary. In a multicounty program, the program director shall be appointed in accordance with the terms of the interlocal agreement, subject to approval by the Secretary.

Except when specifically waived by the Secretary, the program director in a single county program shall meet all the following minimum qualifications:

(1) Masters degree.

(2) Related experience.

(3) Management experience.

(4) Any other qualifications required under G.S. 122C-120.1.

(g) In a single-county program, an advisory committee shall be appointed by the board of county commissioners and shall report to the county manager. The appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements in G.S. 122C-118.1. In a multicounty program, the advisory committee shall be appointed in accordance with the terms of the interlocal agreement.

(h) The county program may contract to provide services to governmental or private entities, including Employee Assistance Programs.

(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". The following sections of this Article do not apply to county programs:

(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.

(2) G.S. 122C-119 and G.S. 122C-119.1.

(3) G.S. 122C-120 and G.S. 122C-121.

(4) G.S. 122C-127.

(5) G.S. 122C-147.

(6) G.S. 122C-152 and G.S. 122C-153.

(7) G.S. 122C-156.

(8) G.S. 122C-158. (2001-437, s. 1.9; 2006-66, s. 10.32(e); 2006-142, s. 4(f), (g), (i), (j).)

§ 122C-115.4. Functions of local management entities.

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, capacity development, and quality control. An LME may remove a provider's endorsement if a provider fails to meet defined quality criteria, fails to adequately document the provision of services, fails to provide required staff training, or fails to provide required data to the LME.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated,

received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.

b. Addressing difficult situations for clients or providers.

c. Consulting with providers regarding difficult or unusual care situations.

d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.

e. Coordinating client transitions from one service to another.

f. Conducting customer service interventions.

g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.

h. Interfacing with utilization reviewers and case managers.

i. Providing leadership on the development and use of communication protocols.

j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an LME may contract with a public or private entity for the implementation of LME functions designated under subsection (b) of this section.

(d) ~~Except as provided in G.S. 122C-124.1 and G.S. 122C-125, the Secretary may neither remove from an LME nor designate another entity as eligible to implement any function enumerated under subsection (b) of this section unless all of the following applies:~~ The Secretary may remove from an LME any LME function(s) enumerated under subsection (b) of this section and designate another entity as eligible to implement the function(s) when:

(1) The LME fails during the previous consecutive three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

~~(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.~~

~~(3) If, after six months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.~~

(e) Notwithstanding subsection (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may ~~temporarily~~ remove an LME function after consultation with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.

~~(3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section.~~ (2006-142, s. 4(d); 2007-323, ss. 10.49(l), (hh); 2007-484, ss. 18, 43.7(a)-(c); 2007-504, s. 1.2.)

§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

(1) Engage in comprehensive planning, budgeting, implementing, and monitoring of community-based mental health, developmental disabilities, and substance abuse services.

(2) Ensure the provision of services to clients in the catchment area, including clients committed to the custody of the Department of Juvenile Justice and Delinquency Prevention.

(3) Determine the needs of the area authority's clients and coordinate with the Secretary and with the Department of Juvenile Justice and Delinquency Prevention the provision of services to clients through area and State facilities.

(4) Develop plans and budgets for the area authority subject to the approval of the Secretary. The area authority shall submit the approved budget to the board of county commissioners and the county manager and provide quarterly reports on the financial status of the program in accordance with subsection (c) of this section.

(5) Assure that the services provided by the county through the area authority meet the rules of the Commission and Secretary.

(6) Comply with federal requirements as a condition of receipt of federal grants.

(7) Appoint an area director in accordance with G.S. 122C-121(d). The appointment is subject to the approval of the Secretary and to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.

(8) Develop and submit to the board of county commissioners for approval the business plan required under G.S. 122C-115.2. A multicounty area authority shall submit the business plan to each participating board of county commissioners for its approval. The boards of county commissioners of a multicounty area authority shall jointly submit one approved business plan to the Secretary for approval and certification.

(9) Perform public relations and community advocacy functions.

(10) Recommend to the board of county commissioners the creation of local program services.

(11) Submit to the Secretary and the board of county commissioners service delivery reports, on a quarterly basis, that assess the quality and availability of public services within the area authority's catchment area. The service delivery reports shall include the types of services delivered, number of recipients served, and services requested but not delivered due to staffing, financial, or other constraints. In addition, at least annually, a progress report shall be submitted to the Secretary and the board of county commissioners. The progress report shall include an assessment of the progress in implementing local service plans, goals, and outcomes. All reports shall be in a format and shall contain any additional information required by the Secretary or board of county commissioners.

(12) Comply with this Article and rules adopted by the Secretary for the development and submission of and compliance with the area authority business plan.

(13) Coordinate with Treatment Accountability for Safer Communities for the provision of services to criminal justice clients.

(14) Maintain a 24-hour a day, seven day a week crisis response service. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers and shall be initiated within one hour of notification. Crisis services do not require prior authorization but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

(a1) The area authority may contract to provide services to governmental or private entities, including Employee Assistance Programs.

(b) The governing unit of the area authority is the area board. All powers, duties, functions, rights, privileges, or immunities conferred on the area authority may be exercised by the area board.

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.

(d) A multicounty area authority shall provide to each board of county commissioners of participating counties a copy of the area authority's annual audit. The audit findings shall be presented in a format prescribed by the county and shall be read into the minutes of the meeting at which the audit findings are presented. (1971, c. 470, s. 1; 1973, c. 476, s. 133; c. 661; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, ss. 1, 3, 14, 23; 1981, c. 51, s. 3; 1983, c. 383, s. 1; 1985, c. 589, s. 2; 1987, c. 830, s. 47(d); 1989, c. 625, s. 14; 1991, c. 215, s. 1; 1995 (Reg. Sess., 1996), c. 749, s. 2; 1997-443, s. 11A.118(a); 1998-202, s. 4(t); 2000-137, s. 4(w).; 2001-437, s. 1.10; 2001-487, s. 79.5; 2005-371, s. 2; 2006-142, s. 3(a).)

§ 122C-118.1. Structure of area board.

(a) An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. The Governor shall appoint one-third of the members of the area board. In a single-county area authority, the remaining members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the remaining ~~other~~ members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the

area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) Except as otherwise provided in this subsection, not more than fifty percent (50%) of the members of the area board shall represent the following:

(1) A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.

(2) A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.

(3) At least one family member or individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals:

a. With mental illness;

b. In recovery from addiction; or

c. With developmental disabilities.

(4) At least one openly declared consumer:

a. With mental illness;

b. With developmental disabilities; or

c. In recovery from addiction.

An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect.

(c) The Governor or the board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity. The terms of county commissioners on an area board are concurrent with their terms as county commissioners. The terms of the other members on the area board shall be for

three years, except that upon the initial formation of an area board one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. Members shall not be appointed for more than two consecutive terms. Board members serving as of July 1, 2006, may remain on the board for one additional term. As vacancies occur on Boards following July 1, 2008, the Governor shall make all appointments until the Governor's appointees represent one-third of the Board.

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes. (2001-437, s. 1.11(b); 2002-159, s. 40(a); 2006-142, s. 4(e); 2007-504, s. 1.4.)

Proposed Special Provision re: Crisis Funds:

Notwithstanding G. S. 122C-112.1(b)(7), the Secretary may contract with one or more private providers or other public agencies to deliver expanded crisis services for which funding is appropriated in this act. The General Assembly supports the plan developed by the Secretary to phase-in the creation of regional management entities over three years through voluntary merger and partnership arrangements among LMEs. The plan, which will be implemented in a single state facility catchment area at a time, will result in the creation of up to eight regional entities serving a total population of at least one million. The Secretary may allocate the expanded crisis services funding appropriated in this act to regional management entities are they are developed

Proposal for Voluntary Regionalization of Local Management Entities

North Carolina currently has twenty-five (25) Local Management Entities (LMEs), under the direction of DHHS, responsible for managing public mental health, developmental disabilities, and substance abuse services at the local level. Having this many local managing agencies is neither an effective nor efficient use of public resources. Too many scarce resources, human and financial, are being consumed on duplicative management and redundant functions while providers and consumers must negotiate 25 different systems. Each LME must administer these systems with limited and dedicated staff. Combining the 25 LMEs into fewer regional entities would improve consistency of services across the state, reduce the barriers to providers delivering services in more than one catchment area, save money and allow personnel to be more effectively utilized. However, recognizing that the public MH/DD/SA system has undergone significant change over the past seven years, making mandatory changes in governance statewide at this point in time could be a concern for the LMEs. Instead, DHHS proposes to achieve the goal of regionalization through a voluntary, phased approach.

DHHS would issue a Request for Proposals inviting the LMEs to voluntarily merge or collaborate through a partnership agreement with the goal of creating no more than three regional entities in one of the state's three state facility catchment areas. (A map of the state facility catchment areas is attached.) LMEs may choose to include in a proposed partnership or merger one LME from another state facility catchment area, but the primary goal of the initiative will be to create a regional presence in one-third of the state at a time. Under this plan, the state will be able to move to no more than nine regional entities over a three year period of time.

The regional entity must meet industry standards for behavioral health managed care organizations, including having a full-time psychiatrist serving as the Medical Director and clinicians with training and expertise in all three disability areas served by the public system. All clinicians must be under the supervision of a master's level licensed clinician and the organization must meet all financial, information technology and claims processing requirements.

In a partnership arrangement, the individual LMEs may continue to exist, with their own Directors, Boards, and Consumer and Family Advisory Committees (CFACs). The individual LMEs may continue to perform certain LME functions, such as care coordination, community collaboration, customer services and provider monitoring, under the auspices of the regional entity. If approved by the Secretary, the LME may also directly deliver services. The regional partnership would be responsible for providing the core managed care functions in an integrated, combined manner. These include screening, triage, and referral; utilization management and utilization review; provider relations, including provider recruitment and contracting; strategic planning for the entire catchment area, including analysis of gaps in services; and quality management. Under a partnership arrangement, the regional entity would be required to have a separate Board of Directors with representation from consumers, families and providers and the partnership would be held to all NC standards for financial management and compliance with open meeting and public records laws.

DHHS will incentivize the development of regional entities by granting all regional entities Single Stream funding and the authority to managed expanded crisis services. The Department will enter into a cost sharing agreement with the regional entity around savings in administrative costs and will endeavor to identify one-time funding to assist regional entities with the costs of implementing a regional model, most notably, information technology

expenses. After one year of operation, if a regional entity is performing satisfactorily, DHHS will delegate to the regional entity the authority to perform utilization management functions for Medicaid services. Regional entities will also be given first consideration for any new initiatives that may become available in the future.

DHHS will evaluate proposals received from LMEs to select the proposals which meet the minimum requirements and achieve the goal of regionalizing one-third of the state at a time. In addition to those factors, DHHS will consider the cost savings associated with proposals and the percentage of overhead cost projected for the regional entity. If proposals are received in the first year that would regionalize more than one of the state's three state facility catchment areas, DHHS will select the best proposals that, in aggregate, represented the best proposals from a single state facility catchment area.

Voluntary LME Regionalization Proposal

State Facility Catchment Areas:

- West: Burke-Catawba, Crossroads, Mecklenburg, Pathways, Piedmont, Smoky Mountain, Western Highlands Network (population 3,400,499)
- Central: Alamance-Caswell-Rockingham, CenterPoint, Durham, Five County, Guilford, OPC, Sandhills, Wake (population 3,178,226)
- East: Albemarle, Beacon, Cumberland, East Carolina, Eastpointe, Johnston, Onslow-Carteret, Southeastern, Southeastern Regional (population 2,390,125)

Proposal:

- DHHS will offer opportunity for LMEs in each state facility catchment area (see above) to voluntarily consolidate/collaborate on a proposal for performing managed behavioral healthcare functions in a combined catchment area in response to a Request for Proposal. Up to three proposals per state facility catchment area will be selected.
- First year awards will be to proposals covering primarily a single state facility catchment area. If proposals from more than one state facility catchment area are received, DHHS will award to the best proposals covering primarily a single catchment area.
- In selecting partners, LMEs may choose to include in the partnership 1 LME located in another state facility catchment area.
- Plan is to move to statewide regionalization over 3 year period.
- Bidders must agree to meet all managed care industry standards, including: competent, experienced clinicians in all 3 disability areas; all clinicians reporting to master's level licensed clinician; full-time psychiatrist serving as Medical Director with direct responsibility for utilization management and quality management; financial; IT; and claims processing requirements.
- Individual LMEs in a group may continue to exist (Boards, Directors, CFACs, some care coordination and customer services functions and, if approved by the Secretary, direct service delivery), but the key managed behavioral healthcare LME functions must be performed in a singular manner, i.e. a single STR unit interfacing with a single utilization management unit using standardized provider relations protocols/requirements, etc.

Criteria for Approval:

- Proposals must meet the minimum requirements outlined above.
- If the proposal does not include a formal merger, the proposal must indicate how the collaborative/consolidated entity will be governed. Minimal requirements will include a Board of Directors with consumer, family and provider representation; compliance with the State's Open Meeting statutes; and compliance with the Local Government Finance Act (G. S. 159).
- Proposals must include information related to projected cost savings.
- Proposals must indicate timeframes for implementation. Minimum requirements will be partial implementation no later than January 1, 2009 and full implementation no later than July 1, 2009.
- Proposals will be evaluated on gross cost savings as well as the overhead percentage projected for the combined entity.

Incentives:

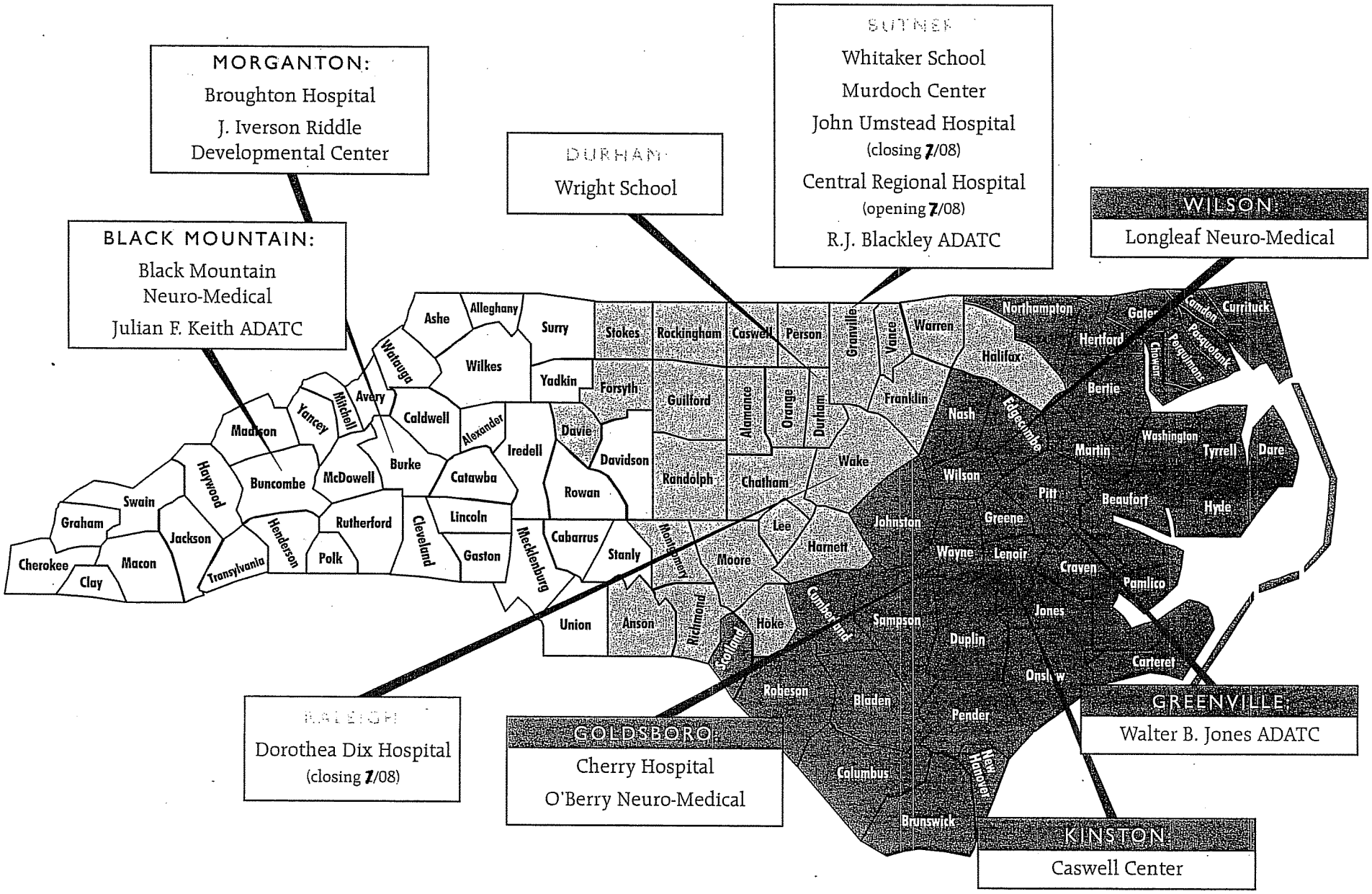
- Responsibility to manage expanded crisis services and associated funding in accordance with a plan approved by DHHS.
- All LMEs in selected regions will move to Single Stream funding for state funds, if not already approved for such. Single Stream funding will be changed to provide quarterly payments, contingent upon continued receipt of "shadow claims" and other financial information.
- Savings associated with economies of scale from consolidation/collaboration to be shared in the following manner: 1st year regional entity retains all savings to offset costs associated with combining functions, 2nd year savings shared 75% regional/25% state, 3rd year and beyond savings shared 50%/50% regional and state.
- DHHS will seek to identify additional one-time money to assist with costs associated with combining functions, such as a single IT software platform, costs associated with integrating telephone systems, etc.
- After one year, if performance is acceptable, successful bidders will be given responsibility to perform UM for Medicaid services.
- Regional entities will be given first consideration for any new initiatives, such as additional "state hospital pilots," 1st Involuntary Commitment Evaluation pilots, future Medicaid waiver activity, etc.

Disincentives:

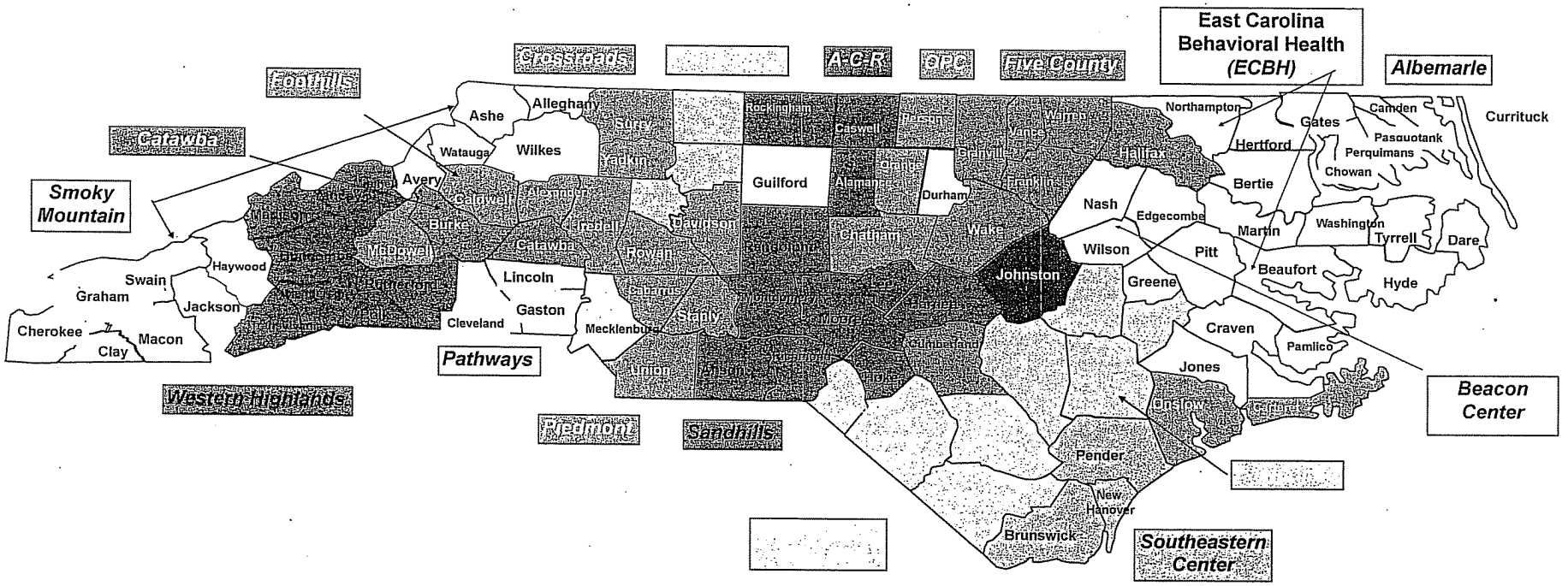
- New crisis funds for all other LMEs will be managed by DHHS, not individual LMEs
- Non-participating LMEs in the selected state facility catchment area will have their LME funding reduced by 10%
- No additional Single Stream funding will be approved for non-participating LMEs

Implementation:

- The elements that would require legislative action are the disincentives – reserving new crisis $ at the state level, reducing LME administration $ for non-participants and halting the advance of Single Stream funding for non-participants.
- Issue RFP by June 1, 2008, responses due back by August 1
- Select from responses by August 31, 2008
- Require management agreements, consolidation plans, etc. from successful bidders to be completed by November 1, 2008.
- Require initial implementation of regional entities by January 1 (some consolidated functions), full implementation by July 1, 2009.


MORGANTON:
Broughton Hospital
J. Iverson Riddle
Developmental Center
BLACK MOUNTAIN:
Black Mountain
Neuro-Medical
Julian F. Keith ADATC
DURHAM:
Wright School
SUTNER
Whitaker School
Murdoch Center
John Umstead Hospital
(closing 7/08)
Central Regional Hospital
(opening 7/08)
R.J. Blackley ADATC
WILSON
Longleaf Neuro-Medical
RALEIGH
Dorothea Dix Hospital
(closing 7/08)
GOLDSBORO
Cherry Hospital
O'Berry Neuro-Medical
GREENVILLE
Walter B. Jones ADATC
KINSTON
Caswell Center
Ashe
Alleghany
Surry
Stokes
Rockingham
Caswell
Person
Granville
Vance
Warren
Northampton
Gates
Currituck
Watauga
Wilkes
Yadkin
Forsyth
Guilford
Alamance
Orange
Durham
Franklin
Halifax
Hertford
Camden
Chowan
Perquimans
Pasquotank
Avery
Mitchell
Yancey
Madison
Caldwell
Alexander
Iredell
Davie
Davidson
Randolph
Chatham
Wake
Nash
Edgecombe
Bertie
Burke
Catawba
Rowan
McDowell
Buncombe
Haywood
Swain
Graham
Jackson
Cherokee
Macon
Clay
Transylvania
Henderson
Rutherford
Polk
Cleveland
Lincoln
Gaston
Mecklenburg
Cabarrus
Stanly
Montgomery
Moore
Lee
Harnett
Johnston
Wilson
Greene
Pitt
Beaufort
Hyde
Martin
Washington
Tyrrell
Dare
Wayne
Lenoir
Craven
Pamlico
Jones
Sampson
Duplin
Onslow
Carteret
Union
Anson
Richmond
Scotland
Hoke
Cumberland
Robeson
Bladen
Pender
New Hanover
Columbus
Brunswick
WESTERN REGION
CENTRAL REGION
EASTERN REGION

Local Management Entities (LMEs) and their Member Counties --- July 2007



The counties within an LME share the same color. Unless otherwise indicated, the LME name is the county name(s).

Dick Oliver, LME Team Leader 919-715-1294

LME TEAM MEMBERS

Yvonne French	Julia Sinclair	Marie Kelley	Mark O'Donnell	Mabel McGlothlen	Rose Burnette	Ken Marsh	Bill Bullington
919-218-6892	(919) 715-1294	(919) 218-5950	(919) 218-7832	(919) 218-1953	(252) 355-9032	(252) 492-6971	(828) 226-3632

NC Mental Health System
(MH/DD/SA)
3 Year Plan

2008-2009

Hospital

- Open 60 Bed Adult Admission Unit at Dorothea Dix after opening of new Central Regional Hospital.
- Funding of additional staff at state psychiatric hospitals to improve staff to patient ratios.
- Funding to improve department level oversight of state hospitals to address compliance and to improve training of staff.
- Funding for recruitment incentives for key hospital positions to address high vacancy rates and work force development incentives especially for Health Care Technicians.
- Follow up on staff to patient ratio concerns expressed by external advisor, Dr. Geller, and Management Operations Advisory Committee by retention of consultant to evaluate staffing ratios for State Psychiatric Hospitals and ADATCs. Report would be given to department and LOC for consideration of overall standard.

Services

- Implement statewide Mobile Crisis Team plan.
- Implement statewide DD Crisis Response Team plan.
- Secure 187 Community Inpatient beds across the state.
- Secure 24 DD Crisis Respite beds across the state.
- Establish walk in crisis and immediate after care capacity across the state, especially where not now available.

Provider Oversight

- Revise appeals system for Medicaid providers and recipients.
- Adopt legislation and execute requirement for national accreditation. Current providers in system for 3 years will have to meet statutory requirements to remain in system.
- Establish 2 year requirement for new providers to achieve national accreditation.
- By June 30, 2009, approximately 50% of current providers would have reached the 3 year deadline for accreditation, and achieved accreditation or be deleted from system.

System Management

One of the 3 state regions is selected to regionalize the LME services into not more than 3 groups. The goal is to shift from 8 LMEs to 3 RMEs in one region during 08-09.

2009-2010

Hospitals
Based on consultant report and subsequent discussions, a second phase of staff adjustments would be implemented for state psychiatric hospitals and ADATCs.

Provider Oversight
Prior to June 30, 2010, another 30% of providers will have reached the 3 year accreditation deadline.

System Management
Selection of 2nd state region for conversion to not more than 3 regional management entities. First Phase regional groups are given Medicaid Utilization Review after satisfactory completion of one year of operations.

2010-2011

Hospitals
Open new Cherry Hospital with associated staffing level adjustment.
Final phase of staffing adjustments at other hospitals and ADATCs pursuant to 2008 consultant study.
Decision will be made on continuation of 60 bed Dix unit based on status of local bed capacity to be developed by Wake County.

Provider Oversight
All remaining providers with involvement in the program prior to June, 2008 will reach the 3 year deadline for national accreditations and will have been accredited or removed from service. New providers becoming associated with Medicaid services between July, 2008 and June, 2009 will reach the 2 year deadline for accreditation and will have been accredited or removed from service.

System Management
Final state region would convert to no more than 3 regional management entities. Second phase regional groups is given Medicaid Utilization after satisfactory completion of one year of operations. Therefore, by June 2011, two thirds of state would have delegated utilization management.